

State of California—Health and Human Services Agency
Department of Health Services



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Director

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DATE: November 23, 2005

MMCD ALL Plan Letter 05010

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: ADVANCE DIRECTIVE FORM

The purpose of this letter is to provide notification that the Medi-Cal Managed Care Division has approved the California Advance Directive Form (English and Spanish versions) for voluntary use by Medi-Cal Managed Care health plans. The document is a good source for general information and also contains several templates to assist members in developing their Advance Directives.

Health plans are required to implement and maintain written policies and procedures respecting Advance Directives in accordance with the requirements of 42 CFR 422.128 and 42 CFR 438.6(i). Therefore, if a plan elects to use the approved form, it should be incorporated into the plan's policies and procedures. Prior to making changes to the form, proposed revisions and modifications must be submitted to the plan's Contract Manager for review and approval.

Plans should follow the instructions in All Plan Letter 00003, Policy and Procedure Revisions, when requesting changes.

If you have any questions, please contact your Contract Manager.

Sincerely,

Vanessa M. Baird, MPPA, Chief
Medi-Cal Managed Care Division

Enclosure

California Advance Health Care Directive

This form lets you have a say about how you want to be treated if you get very sick.

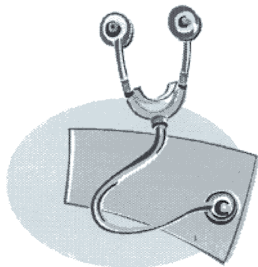


● This form has 3 parts. It lets you:



Part 1: Choose a health care agent.

A health care agent is a person who can make medical decisions for you if you are too sick to make them yourself.



Part 2: Make your own health care choices.

This form lets you choose the kind of health care you want.

This way, those who care for you will not have to guess what you want if you are too sick to tell them yourself.



Part 3: Sign the form.

It must be signed before it can be used.

You can fill out Part 1, Part 2, or both.

Fill out only the parts you want.

Always sign the form in Part 3.

Go to the next page 

If you only want a health care agent go to **Part 1** on page 3

If you only want to make your own health care choices go to **Part 2** on page 6.

If you want both then fill out **Part 1 and Part 2.**

Always sign the form in Part 3 on page 9.

What do I do with the form after fill it out?

Have the form with those who care for you:
doctors
nurses
social workers
family
friends



What if I change my mind?

Change the form
Tell those that care for you about your changes



What if I have questions about the form?

Bring it to your doctors, nurses, social workers
family or friends to answer your questions



What if I want to make health care choices that are not on this form?

- Write your choices on a piece of paper
Keep the paper with this form
- Share your choices with those who care for you



- knows you well
- can be there for you when you need them
- you trust to do what is best for you
- can tell your doctors about the decisions you made on this form

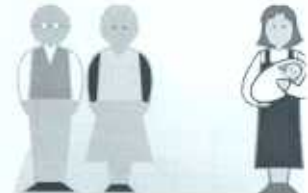


Your agent **cannot** be your doctor or someone who works at your hospital or clinic unless they are a family member.

❶ What will happen if I do not choose a health care agent?

If you are too sick to make your own decisions, your doctors will ask your closest family members to make decisions for you.

If you want your agent to be someone other than family, you must write his or her name on this form.



❷ What kind of decisions can my health care agent make?

Agree to, say no to, change, stop or choose:

- doctors, nurses, social workers
- hospitals or clinics
- medications or tests
- what happens to your body and organs after you die



Go to the next page



- **Feeding Tube**

A tube used to feed you if you cannot swallow. The tube is pushed down your throat into your stomach. It can also be placed directly into your stomach.



- **Blood transfusions**

To put blood in your veins.

- **Surgery**

- **Medicines**

● **End of life care** - if you might die soon your health care agent can help you decide:



- call in a spiritual leader

- decide if you die at home or in the hospital



Show your health care agent this form.

Tell your agent what kind of medical care you want.

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Go to the next page



first name

last name

street address

city

state

zip

() -

() -

home phone number

work phone number

☒ **Put an X next to the sentence you agree with.**

☐ My health care agent can make decisions for me **now**.

☐ My health care agent will make decisions for me **only**
after I cannot make my own decisions.

To make your own health care choices go to part 2 on the next

To sign this form go to part 3 on page 9.

☐ I am not sure

☐ My life is always worth living no matter how sick I am

☒ If I am dying, it is important for me to be:

☐ at home

☐ in the hospital

☐ I am not sure

☒ Is religion or spirituality important to you?

☐ yes

☐ no

☒ What should your doctors know about your religion or spirituality?

If you are sick, your doctors and nurses will always try to keep you comfortable and free from pain.

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Go to the next page



if the treatments **do not work** and there is little hope of getting better, I **do not want to stay** on life support machines.

- ☐ Try all life support treatments that my doctors think might help **but not** these treatments. Mark what you do not want.

☐ CPR

☐ feeding tube

☐ dialysis

☐ blood transfusion

☐ breathing machine

☐ medicine

☐ other treatments _____

- ☐ I **do not want any** life support treatments.

- ☐ I want my **health care agent** to decide for me.

- ☐ I am not sure.

Go to the next page



- An autopsy can be done after death to find out why someone died. It is done by surgery. It can take a few days.



- ☐ I **want** an autopsy.
- ☐ I **do not** want an autopsy.
- ☐ I may want an autopsy if there are questions about my death.
- ☐ I want my **health care agent** to decide.
- ☐ I am not sure.

- What should your doctors know about how you want your body to be treated after you die?
-

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Go to Part 3 on the next page to sign this form

● **Your witnesses must:**

- be over 18 years of age.
- know you.
- see you sign this form.



● **Your witnesses cannot:**

- be your health care agent, doctor, nurse, or social worker.
- benefit financially (get any money) after you die.
- work at the place that you live.
(if you live in a nursing home, go to page 12)

● **Only one witness can be a family member.**

The second witness must be someone other than family.

Witnesses need to sign their names on the next page.

If you do not have witnesses, take this form to a notary public and have them sign on page 10.



Witness #2

sign your name

date

print your first name

print your last name

address

city

state

zip code

You are now done with this form.



Share this form with your doctors, nurses, social workers, friends, and your family.



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Talk with them about your choices.

personally appeared _____
(print name of person completing this form)

and has proved to me on the basis of satisfactory evidence, to be the person whose name indicated on this advance health care directive, and has stated that he or she did complete this form. I declare under penalty of perjury, that the person, whose name is indicated in the advance health care directive, appears to be of sound mind and is under no duress, fraud, or undue influence.

NOTARY SEAL

(Signature)

(Date)

You are now done with this form.



Share this form with your doctors, nurses, social workers, friends, and your family.

Talk with them about your choices.

I am a patient advocate or ombudsman as designated by
the State Department of Aging and that I am serving as a witness
as required by Section 4675 of the Probate Code."

sign your name

date

print your first name

print your last name

address

city

state

zip code

12

Designed by Rebecca Sudano, MD & PM Creative for the San Francisco Department of Public Health